

MEDICAL HISTORY

Name \_\_\_\_\_ Date \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Number and Street City State Zip

Phone # Primary \_\_\_\_\_ Cell/Home Secondary# \_\_\_\_\_ Cell/Home

Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_ Sex – M F Marital Status – S M W O

Spouses Name \_\_\_\_\_ If a child parents name \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer Phone # \_\_\_\_\_ Are we able to call you at work – Yes No

Emergency Contact not living with you – Name \_\_\_\_\_ Phone # \_\_\_\_\_

If completing this form for another person, what is your relationship?

Name \_\_\_\_\_ Relationship \_\_\_\_\_

PLEASE ANSWER EACH QUESTION BELOW – CIRCLE YOUR ANSWERS

1. Physicians name and phone # \_\_\_\_\_

2. Date of last physical exam \_\_\_\_\_

3. Have you had any serious illnesses or been in the hospital in the last 2 years? Yes No

Explain: \_\_\_\_\_

4. Are you taking any drugs or medications? Yes No

Please List all drugs or medications \_\_\_\_\_

5. Are you allergic to penicillin, sulfa, codeine or any other drug or medications ? Yes No

6. (Women) Are you Pregnant? \_\_\_\_\_ Yes No

7. CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR SUSPECTED

- |                   |                        |                       |                  |
|-------------------|------------------------|-----------------------|------------------|
| Acid Reflux       | Epilepsy               | High Blood Pressure   | Sinus Trouble    |
| Alzheimer’s       | Fainting Spells        | Joint Replacement     | Snoring          |
| Anemia            | Frequent Headaches     | Latex Allergy         | Stroke           |
| Arthritis         | GERD                   | Low Blood Pressure    | Thyroid Problems |
| Asthma            | Artificial Heart Valve | Lung Disease          | Tobacco Use      |
| Bleeding Problems | Heart Trouble          | Milk Allergy          | Tuberculosis     |
| COPD              | Hepatitis              | Psychiatric Treatment | Venereal Disease |
| Dementia          | Hiatal Hernia          | Rheumatic Fever       | Cancer _____     |
| Diabetes          | HIV/AIDS               | Seizures              | Other _____      |

8. If you have dental insurance – Policy holder’s name \_\_\_\_\_

Insurance company name and address \_\_\_\_\_

Group Number \_\_\_\_\_ DOB and SS# or ID# of Policy Holder \_\_\_\_\_

Employer Name and Address \_\_\_\_\_

9. If you have additional dental insurance – Policy holder’s name \_\_\_\_\_

Insurance company name and address \_\_\_\_\_

Group Number \_\_\_\_\_ DOB and SS# or ID# of Policy Holder \_\_\_\_\_

Signature of person completing this form

Signature of Dentist

Authorization and Release

I certify that the information provided on my health history has been provided as accurately as possible. I authorize the dentist to release any information, including diagnosis and records of any treatment or examination rendered to me or my child during the period of such dental care, to third party payers and/or health practitioners. I authorize and request my insurance company, should I have insurance and if they will do so, to pay any insurance benefits directly to the treating dentist. I understand that if I have dental insurance and the carrier pays less than the actual fee for services, that I am responsible for those fees. I agree to be responsible for the payment of all services rendered on behalf of me or my dependents, and also for any charges which may arise from collection of those fees.

\_\_\_\_\_  
Signature of patient or parent if patient is a minor

\_\_\_\_\_  
date